

**2002 Maricopa County Maternal and Child Health Needs Assessment
Five-Minute Users Survey**

We want this document to be useful to you. Your reaction to this document is important to us. Please respond to the following questions within 30 days of receipt. Feel free to provide additional comments. After completion of this survey, FAX it to Rose Howe, Family Health Partnerships Manager at (602) 506-6444. Thank you.

Your name: _____ Phone: _____

1. Have you had a chance to use this Needs Assessment? ☐ Yes ☐ No
If yes, what have you used it for? (Please check all that apply)
☐ Grant Writing ☐ Develop new intervention ☐ Policy development
☐ Devise outreach strategies ☐ Other-Please specify. _____
2. Would you like to receive this document every year? ☐ Yes ☐ No
3. Have you viewed this document on our website at: ☐ Yes ☐ No
http://www.maricopa.gov/public_health/epi.asp?
4. Which aspect of the needs assessment did you find most helpful?
5. Which aspect did you find least helpful?
6. Is there a colleague you feel would benefit from receiving this needs assessment? ☐ Yes ☐ No
Please provide name and address:
7. What recommendations would you make to improve this document?